PLEASE REMOVE THIS PAGE AND RETAIN FOR YOUR RECORDS

APPLICATION FOR FAMILY SUPPORT ASSISTANCE July 2005-March 2006 (FY2006)

The Fairfax-Falls Church Community Services Board Mental Retardation Services has funding to provide financial assistance with the ***disability related expenses*** for: **1) families who are primary caregivers and who are living with an individual who is a client of Mental Retardation Services**; **2) adults who are clients of Mental Retardation Services, living independently in the community .** Individuals receiving residential services (i.e. group homes, foster homes, residential schools, institutions, drop-in residential counseling) or waiver services (Medicaid Waiver, Elderly and Disabled Waiver, Developmental Disability Waiver) are not eligible. Eligible families and adults may request assistance with ***disability related costs*** that are not covered by insurance, Medicaid, or other community programs.

Only families completing this Family Support Application can be considered. A completed application should be postmarked by July 15, 2005. The application should estimate the anticipated ***disability related expenses*** the family expects to incur between July 1, 2005 and March 1, 2006. Only expenses incurred within this time frame can be paid for or reimbursed. **The maximum family support available is $1,000.** Families should submit their applications so they are postmarked by July 15, 2005 even if they are still waiting for insurance or Medicaid information. **FAXED OR E-MAILED APPLICATIONS WILL NOT BE ACCEPTED.**

Return the application to:
Mental Retardation Services
12011 Government Center Parkway, Suite 300
Fairfax, VA 22035
ATTN: Family Support Program

You will be notified in writing by August 19, 2005 as to the status of your request. **Please do not submit receipts until you are notified that you are funded.** If you are put on the waiting list, you will receive a letter informing you as such. Since it is possible to be funded from the waiting list, it is advisable to keep receipts relating to your request.

If you have further questions about the Family Support Program, please call Mary Johlfs, Program Coordinator, at (703) 324-4469.

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Date : _____

Person with Disability:

Identifying information:

Name: _____

Adress:_____

City: _____State :_____Zip code: _____

Home phone: _____

Sex: M _____ F _____ Birth date: _____/_____/_____ Social Security Number: _____

Person Requesting Family Support Funds:_____ Relationship: _____

Demographic Information:

Person with the disability resides: In family home: _____ Other (describe):_____

(Check one) City of Fairfax _____ City of Falls Church _____ Fairfax County _____

Race/Ethnic origin: Caucasian/White _____ Black/African American _____ Asian/Pacific Islander _____

Hispanic origin: Puerto Rican _____ Mexican _____ Cuban _____ Other Hispanic _____

Verification of Annual Income

____ Under $25,000

____ $25,000-$49,000

____ $50,000-$74,000

____ $75,000-$99,000

____ Over $100,000

Insurance Information:

Does the person have Medicaid? No___Yes ____ Unsure ____Medicaid number: _____

Does the person have Medicare? No ___Yes _____Unsure____Medicare number: _____

Does the person have other insurance coverage? No _____ Yes _____

***Request Information*:**

Please identify your request in detail explaining expected benefits, cost information, insurance coverage, and the portion of the cost that the family can pay. Most ***disability related*** requests are eligible unless they are part of a county service, or they are considered to be a normal expense such as rent, clothing, utilities, or routine vacation expenses. **Charges from Fairfax County programs (i.e. SACC, Hartwood respite, county recreation programs, county recreation centers) are not eligible as the county is already paying a portion of these fees. The Family Support Program does not pay for respite.** Please contact your Case Manager for information regarding respite.

List each request separately. Attach other pages if needed.

Request : (Describe in detail what is needed and the expected benefit)

_____

_____

_____

_____

Cost: (Describe the cost in detail. For example: speech therapy at $70 per session, twice a month)

_____

_____Amount covered by insurance, Medicaid or other resources.

_____Amount family will pay. This is an amount the family feels is reasonable. (Ex. $2000 toward a wheelchair, $800 toward a computer, or $10 per therapy session). Some families may not be able to afford to help pay a portion of the cost and those families should enter $0. The amount a family can pay does not affect their eligibility or processing of their application.

_____Amount requested from Family Support for this request.

Type of payment I prefer if funded: (Choose only one):

_____ **Reimbursement of receipts.** I understand that if funded, I will pay for the service then submit proof of payment to the Family Support Program and I will be reimbursed. Receipts will be submitted as soon as possible and **no later than March 1, 2006** The person to be reimbursed is:

Name: _____

Street, City, State: _____

ZIP: _____ Social Security Number: _____/_____/_____

Phone (day): _____ (evening): _____

_____ **Direct Payment to the person or company that is providing the above items or services.** I will provide an original bill or invoice and payment will be made directly to the following company, professional or service provider. All bills or invoices will be submitted as soon as possible and no later than **March 1, 2006.** Payment should be made to:

Name of professional or company:_____

Street, City, State: _____

ZIP: _____ Tax ID# or Social Security #: _____

Phone Number: _____

List each request separately. Attach other pages if needed.

Request : (Describe in detail what is needed and the expected benefit)

_____

_____

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Street, City, State: _____

ZIP: _____ Tax ID# or Social Security #: _____

Phone Number: _____

TOTAL AMOUNT REQUESTED FOR ALL ITEMS (MAXIMUM OF $1,000):_____

Comments:

_____

_____

Return completed application with documentation of income to: **Mental Retardation Services, Attention: Family Support, 12011 Government Center Parkway, Suite 300, Fairfax, VA 22035.**